Utah Department of Health
TB Control/Refugee Health Program
MONTHLY TB TEST REPORT

Reporting Agency: _____ Contact Person: _____

Reporting Month: _____ Phone Number: _____

E-mail: _____

Directions: This report is due by the 10th of each month. Please fill in **monthly numbers** for each category.

TB Testing Data

Total Number of TB Skin Tests Administered	
Total Number of TB Skin Tests Read	
Number of TB Skin Tests Positive	
Total Number of QuantiFERON Tests Administered	
Total Number of QuantiFERON Tests Positive	
Total Number of QuantiFERON Tests Negative	
Total Number of QuantiFERON Tests Indeterminate	
Number Receiving X-rays	

Reasons for Testing

Condition for Job/School	
Correctional Facility	
Refugee/Immigrant	
Homeless	
Substance Abuse	
Immunocompromised	
Migrant Farm Worker	
Missionary	
Nursing Home	
TB Contact	
Other	

Age Breakdown

Gender	**Age 0-14**	**Age 15-64**	**Age 65>**	**Total**
Male				
Female				

Race/Ethnicity

American Indian / Alaska Native	
Asian	
Black / African American	
Hispanic / Latino	
Native Hawaiian / Pacific Islander	
White	

Send to: Utah Department of Health, TB and Refugee Health Program Box 142105, Salt Lake City, UT 84114-2105
or E-mail to: TBMonthlyReport@utah.gov Phone: (801) 538-6224 Fax: (801) 538-9913